

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 12597  
 Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Michigan</u>		COUNTY <u>Berrian</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>St. Josephs</u> <u>59X-3</u>			
TOWN <u>Salisbury</u>		<u>3 days</u>		STREET ADDRESS (If rural, give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)				
<u>Florence Barbara Adent</u>			<u>11-25-1955</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>F</u>	<u>W</u>	<u>S</u>	<u>May 9, 1909</u>	<u>46</u>	yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Proff. entertainer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Show business</u>		11. BIRTHPLACE (State or foreign country): <u>Chicago</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Peter Adent</u>				14. MOTHER'S MAIDEN NAME: <u>Bernice Stanislaus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>344-18-8106</u>		<u>Mr. Peter Adent-205 S. Haven St. Salisbury, Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Edema of Brain</u>							
DUE TO							
Antecedent cause(s) (b) <u>Subacute Alcoholism</u>							
DISEASES OR CONDITIONS, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u>Delirium Tremens</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
SIGNATURE <u>Paul L. Royer</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>11-26-55</u>	
		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Rural</u>		DATE THEREOF <u>11/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Casimeras Cem. Chicago, Ill.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>11-26-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>The Hill &amp; Johnson Co. Salisbury, Md</u>		ADDRESS <u>Norman J. Baker</u>	

BUREAU V. S.

JAN 12 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11346

## 11334 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	23X-2
12 TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: <u>Martha Anderson</u>		OF DEATH: <u>November 14 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>June 15, 18 99</u>
9. AGE last birthday: <u>56</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Newark, Md</u>
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>			
13. FATHER'S NAME: <u>Sidney Preston</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine Porter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Gertrude Simmons, R. #3, Berlin</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Hemorrhage, Uterine + Vesical</u>			<u>1 wk</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Metastatic CARCINOMA, Generalized</u>			<u>4 1/2 mos</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CARCINOMA CERVIX, lhp HIV</u>			<u>2 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>13-8-54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>CARCINOMA CERVIX CONFIRMED</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/14</u> , 19 <u>55</u> , to <u>11/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>55</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
SIGNATURE: <u>Theresa Hansen M.D.</u>		ADDRESS: <u>Salisbury, Md</u>	
DATE SIGNED: <u>11-15-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>11-17-55</u>		<u>William's Cemetery</u>	
<u>Newark, Md</u>			
DATE REC'D BY LOCAL REGISTRAR: <u>11-15-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR: <u>Clay C. Dennis, Snow Hill, Md.</u>		ADDRESS:	

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11347

## 11335 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>About 10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82</u> <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>615 W. Main Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>William</u> <u>James</u> <u>Austin</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11</u> - <u>16</u> - <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	B. DATE OF BIRTH <u>1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Austin</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-2774</u>		17. INFORMANT & ADDRESS <u>Salisbury, Md.</u> <u>Mrs. Florence Austin, 615 W. Main St.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Subdural Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				Indefinite			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>22 Oct</u> , 19 <u>55</u> , to <u>16 Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>16 Nov</u> , 19 <u>55</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Starnell</u>		ADDRESS (Street, city, town, state) <u>M.D. 6 (214) main Salisbury Md</u>		DATE SIGNED <u>20 Nov 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>11-20-55</u>	NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		LOCATION (City, town, or county) <u>Quantico, Wicomico Co., Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>11-22-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>Stewart Funeral Home Salisbury, Md.</u>			

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11336 **CERTIFICATE OF DEATH**

11348

Dr. Juerman

Reg. Dist. No. ....

**1. PLACE OF DEATH**

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL OR end give nearest town) Salisbury, Maryland LENGTH OF STAY (in this place) 10 mo. 26 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 25, Maryland

STREET ADDRESS (If rural give location) 4210 Fourth Street

**3. NAME OF DECEASED**  
(Type or Print)

(First)

(Middle)

(Last)

John

Banglesdorf

**4. DATE OF DEATH**

(Month)

(Day)

(Year)

Nov. 20

19 55

5. SEX  
Male

6. COLOR OR RACE  
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH

April 26, 1886

9. AGE last birthday  
69 yrs.

IF UNDER 1 YEAR  
Months Days

IF UNDER 24 HRS.  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk

10b. KIND OF BUSINESS OR INDUSTRY  
unk

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
USA

13. FATHER'S NAME

Karl Banglesdorf

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

unk

17. INFORMANT & ADDRESS

Hospital Records

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

600.0 IMMEDIATE CAUSE (A)

Uremia

INTERVAL BETWEEN ONSET AND DEATH

3 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

Chronic Pyelonephritis

2 years

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)

Ca. of Prostate Gland w/metastasis

3 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

**22. I hereby certify** that I attended the deceased from Feb. 25, 19 55, to Nov. 20, 19 55, that I last saw the deceased alive on Nov. 20, 19 55, and that death occurred at 8:45 A.M. from the causes and on the date stated above.

SIGNATURE

Dr. Juerman

M.D.

ADDRESS (Street, city, town, state)

Salisbury, Maryland

DATE SIGNED

11/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

DATE THEREOF

Nov. 23, 1955

NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

LOCATION (City, town, or county)

Anne Arundel County, Maryland

24. REC'D BY REGISTRAR  
DATE NOV 21 1955

REGISTRAR'S SIGNATURE

Mary J. Holloway

25. FUNERAL DIRECTOR'S SIGNATURE

Howard Evans

ADDRESS

1400 S. Ches St. Balt. Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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NOV 21 1955

BUREAU V. S.

1955 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12



11337

11349

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

## 1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury LENGTH OF STAY (in this place) life  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS E. Church St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico  
 CITY (If outside corporate limits write RURAL and give nearest town) Fruitland OR TOWN Fruitland X  
 STREET ADDRESS (If rural, give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

LutherBeavins

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

11201955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

## IF UNDER 1 YEAR IF UNDER 24 HRS.

MCWidow18 8570 66Yrs.MonthsDaysHoursMin.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

FarmerFarmerChance mdU.S.A.

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## INTERVAL BETWEEN ONSET AND DEATH

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## Immediate cause

(a)

Coronary occlusion

DUE TO

Sudden

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause

DUE TO

stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Store

## 21c. (City or town)

(County)

(State)

SalisburyWicomicoMaryland

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

## CHIEF MEDICAL EXAMINER

## DATE SIGNED

M. D.

## DEPUTY MEDICAL EXAMINER

11-24-55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Burial11-24-55Bierens CemFruitland md11-26-55Mary W. HollowayBooker M. HuntSalisbury md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 08 1955

RECEIVED

## 11338 CERTIFICATE OF DEATH

11350

332

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		Since 11/21/55		CITY OR TOWN <u>Cambridge</u>		09X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>RFD #3</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>John</u> (Middle) <u>William</u> (Last) <u>Bennett</u>				Nov. 30 19 55			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
Male	White	Married	S pt. 27, 1894	61 yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Seafood</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cambridge, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas E. Bennett</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Susie Rhea</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes World War I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-16-7389</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>self when admitted</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
162X IMMEDIATE CAUSE (A) <u>pulmonary Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of lung (Bronchogenic)</u>				<u>8 mo.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov. 21, 1955, to Nov. 30, 1955, that I last saw the deceased alive on Nov. 30, 1955, and that death occurred at 3:30 a.m. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>11/30/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/2/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Memorial Park</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Cambridge Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>ADDRESS</b> <u>LeCompte Funeral Service Cambridge, Md.</u>	
<b>DATE</b> <u>Dec 1, 1955</u>							

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

DATE OF DEATH

STANDARD REPORTING FORM NO. 10-55

DEATH OF THE  
DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

NOTICE TO THE PUBLIC

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE DEATH IS PROPERLY REGISTERED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE DEATH IS PROPERLY REGISTERED IF IT IS FILED IN THE DEATH REGISTER WITHIN THE PRESCRIBED TIME LIMIT. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE DEATH IS PROPERLY REGISTERED IF IT IS FILED IN THE DEATH REGISTER WITHIN THE PRESCRIBED TIME LIMIT.

BUREAU V. S.

DEC 5 1955

RECEIVED

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11339 CERTIFICATE OF DEATH

11351

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hillsboro</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) ✓			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>James</u>		(Middle) <u>Edgar</u>		(Last) <u>Blades</u>		(Month) (Day) (Year) <u>Nov. 16 19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/23/1887</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School bus driver</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Blades</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Louise Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>Acute myocardial failure</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
(C) <u>Old CVA with residual hemiplegia</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 17, 19 52</u> , to <u>Nov. 16, 19 55</u> , that I last saw the deceased alive on <u>Nov. 16, 19 55</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D.		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital Salisbury, Maryland</u>		DATE SIGNED <u>11/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmont</u>		LOCATION (City, town, or county) (State) <u>Hillsboro Md</u>	
24. REC'D BY REGISTRAR DATE <u>11-22-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moor &amp; Son</u>		ADDRESS <u>Denton Md</u>	

# RECEIVED BUREAU V. S. NOV 25 1955

RECEIVED STATE DEPARTMENT OF HEALTH - BATHING

## CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. DATE OF DEATH                  [Faint text]</p>	
<p>7. CAUSE OF DEATH                  [Faint text]</p>		<p>8. PLACE OF DEATH                  [Faint text]</p>	
<p>9. SIGNATURE OF DECEASED                  [Faint text]</p>		<p>10. SIGNATURE OF WITNESS                  [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>12. SIGNATURE OF CORONER                  [Faint text]</p>	
<p>13. SIGNATURE OF JURY                  [Faint text]</p>		<p>14. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>15. SIGNATURE OF CLERK                  [Faint text]</p>		<p>16. SIGNATURE OF NOTARY                  [Faint text]</p>	

RECEIVED  
 BUREAU V. S.  
 NOV 25 1955



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11340 Item 7, Film G189, 11/25/55 fcy  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11352  
 Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Vienna</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)			(First)	(Middle)	(Last)	4. DATE OF DEATH	
<u>James</u>				<u>Branch</u>		<u>11</u>	<u>6</u> <u>19</u> <u>55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>M</u>	<u>C</u>	<u>Unknown</u>		<u>Feb. 12, 1918</u>		<u>37</u> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Saw Mill</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>Yes</u>		<u>W.W. II</u>		<u>212-16-1662</u>		<u>Sallie Garrison, Cambridge, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shotgun wound of the abdomen</u>						<u>3</u> hrs.	
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>11-6-55</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u> )		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				<u>Vienna - Wicomico</u>		<u>MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11-6-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot with 12 gauge shotgun during quarrel.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-7-55</u>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal-Burial</u>		<u>11/11/1955</u>		<u>Waugh Cemetery</u>		<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>11-10-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Herbert M. St. Clair, Jr., Cambridge, Md.</u>			

BUREAU V. E.

NOV 17 1955

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11353

## 11341 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>				12 TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hosp.</u>				134 <u>Delaware Ave.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Selina Mae Brown</u>				<u>11 14 1953</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>F</u>	<u>C</u>	<u>Married</u>	<u>9-13-1911</u>	<u>44 yrs.</u>	Months <u>2</u> Days <u>1</u>	Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Laborer</u>		<u>Canning Factory</u>		<u>Ocean City, Md</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Frederick Bowen</u>				<u>Henrietta Pitts</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>No</u>		<u>Nelson Brown 134 Delaware St Salisbury Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>331 X</u>				<u>Intracerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>3 to 4 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Essential Hypertension</u>				<u>year or more</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Nov. 13, 1953</u>, to <u>Nov. 14, 1953</u>, that I last saw the deceased alive on <u>Nov. 14, 1953</u>, and that death occurred at <u>3a</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>G. Herbert Sembley M.D.</u>				<b>ADDRESS (Street, city, town, state)</b> <u>Salisbury Md</u>		<b>DATE SIGNED</b> <u>11/14/53</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>11-17-53</u>		<u>Green Acres Memorial Park</u>		<u>Salisbury, Wicomico Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>11-15-53</u>		<u>Mary W. Holloray</u>		<u>Mary C. Stewart</u>		<u>J. R. Stewart Funeral Home, Salisbury, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104M

CERTIFICATE OF DEATH

Decedent: *William A. Brown*  
Age: *44* years  
Sex: *M*  
Race: *W*  
Date of Death: *Nov 17 1955*  
Place of Death: *134 Delaware Ave*  
Cause of Death: *Myocardial Infarction*  
Manner of Death: *Natural*

BUREAU V. 2

NOV 17 1955

RECEIVED

35

TO VITAL RECORDS DIVISION, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND  
FROM: [illegible]  
RE: [illegible]  
[illegible text continues]

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11342 CERTIFICATE OF DEATH

Reg. Dist. No. 11354 320

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 Salisbury</u>		LENGTH OF STAY (in this place) <u>3 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>20x-2 St. Michaels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>--</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Dorah</u> <u>--</u> <u>Butler</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov.</u> <u>17</u> <u>19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Jan. 20, 1868</u>	<b>9. AGE last birthday</b> <u>87</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>--</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>--</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John Butler</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Brown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>--</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>5 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>STATING UNDERLYING CAUSE LAST.</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>8/8</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>8/8</u> , 19 <u>55</u> , to <u>11/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>55</u> , and that death occurred at <u>5:35P</u> .M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. V. J. Jernigan</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Deer's Head Hosp, Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>11/17/55</u>	
<b>23. BURIAL, CREMATION, REMOVEAE (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>11/21/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Michaels C.E.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>St. Michaels Spd</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Norman D. Marsh</u>		<b>ADDRESS</b> <u>St. Michaels Md.</u>	
<b>DATE</b> <u>Nov. 22, 1955</u>							

# 1912 CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

OCCUPATION

EDUCATION

BUREAU V. S.

NOV 23 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 11343

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12477

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 TOWN Salisbury</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Selbyville</u> <span style="float: right;"><u>46X-3</u></span>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>R F D # 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William H Butler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11-4-1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>June 1 1928</u>	9. AGE last birthday: <u>27</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Sun Oil Company</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Vernon Butler</u>				14. MOTHER'S MAIDEN NAME: <u>Rutha Evers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Walter Farley Frankel Water</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							6 days
(a) <u>Fractured skull: crushed chest.</u> Immediate cause DUE TO							
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) (County) (State) <u>Pittsville Wicomico Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 29 55 11PM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Two car head on collision.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Paul H. Roy</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>12-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burnt</u>		DATE THEREOF <u>Nov 7 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Reston</u>		LOCATION (City, town, or county) (State) <u>Pittsville Delaware</u>	
DATE REC'D BY LOCAL REG. <u>12-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary D. Hollaway</u>		24. FUNERAL DIRECTOR <u>Hill and Johnson</u>		ADDRESS <u>Watson + Farley Frankel Water</u>	

BUREAU V. A.

DEC 12 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 11355  
 Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Near Rockawalkin</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
		<u>John</u>				<u>Byrd</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>C o l o r e d</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>About 1912</u>	
9. AGE last birthday: <u>About 43</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Wicomico County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Samuel Byrd</u>		14. MOTHER'S MAIDEN NAME: <u>Emma (maiden name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>219-14-4043</u>		17. INFORMANT & ADDRESS: <u>George Byrd, Salisbury, Md., R.F.D.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
<u>981X</u> Immediate cause (a)..... <u>Shotgun wound of the head</u> ..... DUE TO Antecedent cause(s) Diseases or conditions, if any, (b)..... giving rise to the above cause DUE TO stating underlying cause last (c).....				<u>Sudden</u> .....	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11</u> <u>5</u> <u>55</u> <u>10:30</u> P.M. <input type="checkbox"/> work <input checked="" type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
21f. HOW DID INJURY OCCUR? <u>Gunfight between two men while drinking.</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , <u>Homicide</u> <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Emil R. Byrd</u>		M. D. <u>Emil R. Byrd</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Nov. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Rockawalkin, Maryland</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>			
DATE REC'D BY LOCAL REG. <u>11-19-55</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u> <u>Margaret W. Hollisray</u>			

 20. AUTOPSY?  
 Yes ☒ No ☐

(State)

(County)

(City or town)

(Month) (Day) (Year)

(Hour)

(Type or Print)

(Specify)

(First)

(Middle)

(Last)

(Type or Print)

(Specify)

(First)

(Middle)

(Last)

BUREAU V. S.

NOV 23 1955

RECEIVED

11379

## CERTIFICATE OF DEATH

11356  
Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Pittsville</i>		LENGTH OF STAY (in this place) <i>43 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pittsville</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <i>Ella</i>		(Middle) <i>M.</i>		(Last) <i>Bamphill</i>		(Date) <i>Nov. 18 1955</i>	
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>March 26 - 1881</i>	
9. AGE last birthday: <i>74</i>		10. AGE UNDER 1 YEAR: <i>74/7/22</i>		11. AGE UNDER 24 HRS. Months: <i>22</i> Days: <i>22</i> Hours: <i>22</i> Min. <i>yes</i>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>			
11. BIRTHPLACE (State or foreign country): <i>Berlin, md</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <i>Joshua Nichols</i>				14. MOTHER'S MAIDEN NAME: <i>Leah Powell</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or ink.) (If Yes, give war or dates of service): <i>no</i>				16. SOCIAL SECURITY NO.: <i>none</i>			
17. INFORMANT'S ADDRESS: <i>Mr. Paul J. Bamphill, Pittsville, md</i>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				<i>Immediate</i>			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C) <i>Cerebral arteriosclerosis</i>				<i>?</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hypertensive Cardiovascular Disease</i>				<i>5-6 yrs</i>			
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/26, 1950</i> to <i>10/29, 1955</i> , that I last saw the deceased alive on <i>10/29, 1955</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Ernest M. Lamm</i>				ADDRESS <i>Belmer, Del</i> DATE SIGNED <i>11/19/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <i>Burial</i>		DATE THEREOF: <i>Nov. 21/55</i>		NAME OF CEMETERY OR CREMATORY: <i>Grace Methodist</i>		LOCATION (City, town, or county) (State): <i>Pittsville, md</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>11-22-55</i>		REGISTRAR'S SIGNATURE: <i>Mary W. Hollows</i>		FUNERAL DIRECTOR: <i>Elmer C. Harris, Snow Hill, md</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 25 1955

BUREAU V. S.



11344 **CERTIFICATE OF DEATH**

11357

Reg. Dist. No. ....

## INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place) <b>10 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>		<b>19X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>82 Peninsula General Hospital</b>				STREET ADDRESS (If rural give location) <b>Route # 1 Box 29</b>		✓	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>Littleton James Cannon</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 - 14 - 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>1884</b>	<b>9. AGE last birthday</b> <b>71 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Saw Mill</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Somerset County, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John Cannon</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Amanda Cannon</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-18-6277</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Blanche Polk, Eden, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>443X IMMEDIATE CAUSE (A)</b> <b>Chronic Nephritis</b>						<b>6 mos</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Chronic Nephrositis</b>						<b>?</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Osteoarthritis</b>						<b>club</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Hypertension</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Nov 15, 19 55</b> , to <b>Nov 14, 19 55</b> , that I last saw the deceased alive on <b>Nov 14, 19 55</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>G. Herbert Lumbly</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Salisbury Md</b>		<b>DATE SIGNED</b> <b>11/15/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11-20-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Mary's Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>West Post Office, Somerset Co Md.</b>	
<b>24. REC'D BY REGISTRAR</b> DATE <b>11-15-55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Manly W. Holloray</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary A. Stewart</i>		<b>ADDRESS</b> <b>Salisbury, Md.</b>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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BUREAU V. 3

1955

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11380 CERTIFICATE OF DEATH

1358

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR TOWN)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN			
<u>Allen</u>		<u>10 Yrs.</u>		<u>Allen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Eden Rt. #2</u>				<u>Eden Rt. #2</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(Type or Print) <u>ELLEN PAYNE COOPER</u>				(Month) (Day) (Year) <u>11 3 19 55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>Dec. 15, 1915</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		IF UNDER 1 YEAR	
<u>House Wife</u>		<u>Own Home</u>		<u>39</u> yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>Maryland</u>				<u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>E. Grice Payne</u>				<u>Lida Paradie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>None</u>		<u>Mr. Levin T. Cooper, Same</u>			
<b>18. MEDICAL CERTIFICATION</b>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>156.1 IMMEDIATE CAUSE (A) <u>Anemia</u></u>							
ANTECEDENT CAUSE(S) DUE TO <u>Carcinoma of liver &amp;</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>mesenteric metastasis.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>2/7</u> , 19 <u>55</u> , to <u>11/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>55</u> , and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Andrew C. Mitchell</u>				ADDRESS (Street, city, town, state) <u>Salisbury Ind</u>		DATE SIGNED <u>11/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/6/55</u>		<u>Allen Cemetery</u>		<u>Allen, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov 7 1955</u>		<u>Mary H. Holloway</u>		<u>The Hill &amp; Johnson Co.</u>		<u>Salisbury, Maryland</u>	
				<u>Norman T. Baker</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

County of \_\_\_\_\_

Dec. 1919

Male

Age

Color

Married

10 Yrs.

White

John Doe

John Doe

1919

1919

1919

1919

30

Dec. 1919

Dec. 1919

Dec. 1919

1919

1919

1919

1919

1919

1919

1919

1919

Signature of John Doe  
1919

BUREAU V. S.

22

11/3

22

2/7

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11/3

Signature of John Doe

RECEIVED

11/21/22

Signature of John Doe

1919

1919

1919

11381

12483

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Tyaskin</i>	LENGTH OF STAY (in this place) <i>Lifetime</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Tyaskin</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <i>Marcellus</i>		4. DATE OF DEATH <i>11-23</i> 19 <i>55</i>	
(First) (Middle) (Last)			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>3-6-1875</i>
9. AGE last birthday: <i>80</i> yrs.		10. IF UNDER 1 YEAR: <i>8</i> Months <i>17</i> Days <i>17</i> Hours <i>17</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Own Farm</i>	
11. BIRTHPLACE (State or foreign country): <i>Tyaskin, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Marcellus V. Dashiield</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <i>4875</i>		16. SOCIAL SECURITY No.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Wore Bettis, Tyaskin, Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) <i>Cerebral Hemorrhage</i> DUE TO Antecedent cause(s) (b) <i>Hypertensive C.V. Disease</i> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>11-28-55</i>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Emil L. Ruge</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>11-28-55</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>11-28-55</i>	
NAME OF CEMETERY OR CREMATORY: <i>Festerville Cemetery</i>		LOCATION (City, town, or county) (State): <i>Festerville, Maryland</i>	
DATE REC'D BY LOCAL REG. <i>12-3-55</i>		REGISTRAR'S SIGNATURE: <i>Mary W. Hollonay</i>	
24. FUNERAL DIRECTOR: <i>Connelley S. Messick, Bivolve, Md.</i>		ADDRESS:	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

DEC 8 1955

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11345 CERTIFICATE OF DEATH

11359

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1</u> year		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fairmount</u>		<u>18X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>George</u>		(Middle) <u>Henry</u>		(Last) <u>Dize</u>		<u>Nov. 15</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 18, 1856</u>	9. AGE last birthday <u>99</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Dize</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Fannie Tyler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						-	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
<u>260.8</u> (C) <u>Bronchopneumonia</u>						24 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus; CNS syphilis</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that</b> attended the deceased from <u>Nov. 29</u> , 19 <u>54</u> , to <u>Nov. 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 15</u> , 19 <u>55</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>L.V. Maldve, M.D.</u> <b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u> <b>DATE SIGNED</b> <u>11/15/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Nov. 17, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Kopf P. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Upper Fairmount, Md</u>			
24. REC'D BY REGISTRAR DATE <u>11-18-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey B. Miller</u> ADDRESS <u>Upper Fairmount, Md</u>				

# CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED (Print Name of Deceased)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print Name of Occupation)

7. CAUSE OF DEATH (Print Name of Cause of Death)

8. MANNER OF DEATH (Print Name of Manner of Death)

9. PLACE OF DEATH (Print Name of Place of Death)

10. DATE OF DEATH (Month, Day, Year)

11. SIGNATURE OF PHYSICIAN (Print Name of Physician)

12. SIGNATURE OF REGISTRAR (Print Name of Registrar)

13. SIGNATURE OF WITNESS (Print Name of Witness)

14. SIGNATURE OF DECEASED (Print Name of Deceased)

15. SIGNATURE OF NEXT OF KIN (Print Name of Next of Kin)

16. SIGNATURE OF CLERK (Print Name of Clerk)

17. SIGNATURE OF CHURCH CLERK (Print Name of Church Clerk)

18. SIGNATURE OF MINISTERS (Print Name of Ministers)

19. SIGNATURE OF RABBI (Print Name of Rabbi)

20. SIGNATURE OF OTHER (Print Name of Other)

21. SIGNATURE OF DECEASED (Print Name of Deceased)

22. SIGNATURE OF NEXT OF KIN (Print Name of Next of Kin)

23. SIGNATURE OF CLERK (Print Name of Clerk)

24. SIGNATURE OF CHURCH CLERK (Print Name of Church Clerk)

25. SIGNATURE OF MINISTERS (Print Name of Ministers)

26. SIGNATURE OF RABBI (Print Name of Rabbi)

27. SIGNATURE OF OTHER (Print Name of Other)

28. SIGNATURE OF DECEASED (Print Name of Deceased)

29. SIGNATURE OF NEXT OF KIN (Print Name of Next of Kin)

30. SIGNATURE OF CLERK (Print Name of Clerk)

1. NAME OF DECEASED (Print Name of Deceased)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print Name of Occupation)

7. CAUSE OF DEATH (Print Name of Cause of Death)

8. MANNER OF DEATH (Print Name of Manner of Death)

9. PLACE OF DEATH (Print Name of Place of Death)

10. DATE OF DEATH (Month, Day, Year)

11. SIGNATURE OF PHYSICIAN (Print Name of Physician)

12. SIGNATURE OF REGISTRAR (Print Name of Registrar)

13. SIGNATURE OF WITNESS (Print Name of Witness)

14. SIGNATURE OF DECEASED (Print Name of Deceased)

15. SIGNATURE OF NEXT OF KIN (Print Name of Next of Kin)

16. SIGNATURE OF CLERK (Print Name of Clerk)

17. SIGNATURE OF CHURCH CLERK (Print Name of Church Clerk)

18. SIGNATURE OF MINISTERS (Print Name of Ministers)

19. SIGNATURE OF RABBI (Print Name of Rabbi)

20. SIGNATURE OF OTHER (Print Name of Other)

21. SIGNATURE OF DECEASED (Print Name of Deceased)

22. SIGNATURE OF NEXT OF KIN (Print Name of Next of Kin)

23. SIGNATURE OF CLERK (Print Name of Clerk)

24. SIGNATURE OF CHURCH CLERK (Print Name of Church Clerk)

25. SIGNATURE OF MINISTERS (Print Name of Ministers)

26. SIGNATURE OF RABBI (Print Name of Rabbi)

27. SIGNATURE OF OTHER (Print Name of Other)

28. SIGNATURE OF DECEASED (Print Name of Deceased)

29. SIGNATURE OF NEXT OF KIN (Print Name of Next of Kin)

30. SIGNATURE OF CLERK (Print Name of Clerk)

RECEIVED

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

RECEIVED  
NOV 21 1955  
BUREAU V. S.

11346

## CERTIFICATE OF DEATH

11360

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		2 months		TOWN <u>Olney</u>		15X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Joseph</u>		(Middle)		(Last) <u>Dyer</u>			
				MONTH <u>11</u>		DAY <u>3</u> YEAR <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>?</u>	8. DATE OF BIRTH <u>9/16/1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Gangrene of right leg due to endarteritis</u>						1 week	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general and cerebral</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Hypertensive arteriosclerotic cardiovascular disease</u>						?	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 29</u> , 19 <u>55</u> , to <u>Nov. 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>55</u> , and that death occurred at <u>3:00A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. Juerman</u> V. Juerman, M.D.				ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>11/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/5/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, or county) (State) <u>Switzland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Regis R. Webb</u>		ADDRESS <u>741-11th St. S.E.</u>	
DATE <u>10/5/55</u>							

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

REG. GEN. NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

HABIT AND OCCUPATION

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

ETHNIC ORIGIN

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

RECEIVED

NOV 8 1935

NOV 8 1935

RECEIVED

BUREAU V. S.

11392

11361

Reg. Dist.

No. 332

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

COUNTY **Wicomico**

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN **Rural Salisbury**

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

**R.D. # 5 (Ocean City Rd)**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Wicomico**

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN

**Salisbury Rural**

STREET ADDRESS

(If rural, give location)

**R.D. # 5 (Ocean City Rd.)**

## 3. NAME OF DECEASED: (Type or Print)

(First) **HENRY**(Middle) **LEE**(Last) **FARLOW**

## 4. DATE OF DEATH

(Month) **NOV.**(Day) **11**(Year) **19 55**

## 5. SEX:

**Male**

## 6. COLOR OR RACE:

**White**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

**Married**

## 8. DATE OF BIRTH:

**May 8th 1878**

## 9. AGE last birthday:

**77**

yrs.

IF UNDER 1 YEAR

Months **6**

IF UNDER 24 HRS.

Days **3**Hours **11**Min. **55**

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

**Retired Farmer**

## 10b. KIND OF BUSINESS OR INDUSTRY:

**Farming**

## 11. BIRTHPLACE (State or foreign country):

**Pittsville, Maryland**

## 12. CITIZEN OF WHAT COUNTRY?

**USA**

## 13. FATHER'S NAME:

**John William Farlow**

## 14. MOTHER'S MAIDEN NAME:

**(Unk) Leonard**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**Unk**

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

**Mr. Joseph W. Farlow (Son) R.D. # 5 (Ocean City Road) Salisbury, Maryland**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**420.1 Immediate cause**(a) **Coronary Occlusion**  
DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **Nov. 11 1955**  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. ☐

## 23. BURIAL, CREMATION, REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

**11-14-55****Mary W. Holloway****HOLLOWAY & COMPANY****SALISBURY MARYLAND**

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

OV 17 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Earl Royer - Med Exam. 11347

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 11362

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN <b>Salisbury</b>	
TOWN <b>Salisbury</b>				TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>On Boat Off-Fitzwater St. On Wicomico River</b>				STREET ADDRESS (If rural, give location) <b>Fitzwater St.</b>			
3. NAME OF DECEASED: (Type or Print)		(First) <b>DAVID</b>		(Middle) <b>GAULT</b>		(Last) <b>FIGGS</b>	
4. DATE OF DEATH		(Month) <b>NOV.</b>		(Day) <b>3</b>		(Year) <b>19 55</b>	
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Aug. 11, 1895</b>	<b>60</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Laborer on Pile Driver Boat</b>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Pittsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>William Levi Figgs</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Ellen Gault</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Mr. Harold D. Figgs (Son) Cambridge, Maryland</b>			
<b>Unk</b>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <b>Coronary occlusion</b>							<b>Sudden</b>
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Earl Royer</b>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>Nov. 7 1955</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>Nov. 8, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		LOCATION (City, town, or county) (State) <b>Berlin, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>11-8-55</b>		REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>		24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	

BUREAU V. 1

ON 17 1955

RECEIVED

11348

11363  
Reg. Dist.

204 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

## 1. PLACE OF DEATH:

COUNTY Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)TOWN SalisburyLENGTH OF STAY  
(in this place)7 days

HOSPITAL OR

INSTITUTION OR

STREET ADDRESS Peninsula General Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN SalisburySTREET  
ADDRESS

(If rural, give location)

Westover Circle3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JohnFletcher

4. DATE

(Month)

(Day)

(Year)

OF  
DEATH11291955

## 5. SEX:

M6. COLOR OR  
RACE:C7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Married

## 8. DATE OF BIRTH:

1905

## 9. AGE last birthday:

50 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):Labor10b. KIND OF BUSINESS OR  
INDUSTRY:none

## 11. BIRTHPLACE (State or foreign country):

East New Market12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

John Fletcher

## 14. MOTHER'S MAIDEN NAME:

Elizabeth Carter15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY No.:

217-22340

## 17. INFORMANT &amp; ADDRESS:

Vergenia Cingulatus

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) Cerebral hemorrhage

DUE TO

Pulmonary embolus with infarction

Antecedent cause(s)

Diseases or conditions, if any,

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

Mural thrombus, right atriumHypertensive cardio-vascular diseaseINTERVAL BETWEEN  
ONSET AND DEATH7 days

Months

Years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY

## 21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21e. INJURY OCCURRED  
While at Not while  
work ☐ at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Paul H. RoyceCHIEF MEDICAL EXAMINER ☒

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☒

M. D.

ASSISTANT MEDICAL EXAM. ☐11-30-5523. BURIAL, CREMATION,  
REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

12-2-55Mary W. HollowayBooker M. Lockett

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

March 1962

Bank New York

Letter from

Director General

John A. ...

... Corporation

BUREAU V. S.

DEC 5 1955

RECEIVED

15-3-22 Bureau of ...

... Bureau

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled in by the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11349

## CERTIFICATE OF DEATH

11364

Dr. Gilmore &amp; Ellis

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) <b>12 TOWN Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 1011 East Church St</b>				STREET ADDRESS (If rural give location) <b>1011 East Church St</b>		<b>1</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>EMMA FOX FURNESS</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>NOV. 10th 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>July 28, 1909</b>	<b>9. AGE last birthday</b> <b>46</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Snow Hill Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Fox</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Carrie Hall</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. James Russell Furness (Husband) 1011 East Church St Salisbury Maryland</b>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <b>420.1 IMMEDIATE CAUSE (A) Coronary Artery Heart Disease 1 yr.</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arricular fibrillation</b>				<b>1 week</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> M. el work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 25, 1955 to Nov 10, 1955, that I last saw the deceased alive on Nov 10, 1955, and that death occurred at 3:15 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>David J. Gilmore</b>		<b>M.D. Salisbury, Maryland</b>		<b>ADDRESS (Street, city, town, state)</b> <b>Nov. 11 1955</b>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 13, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REGD BY REGISTRAR</b> <b>DATE</b> <b>Nov. 14, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

1991

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BUREAU V. S.

NOV 4 1955

RECEIVED



## 11350 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dean City</u>	<u>23X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>		STREET ADDRESS (If rural give location) <u>A7D#1</u>	✓
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>James</u>	(Middle)	(Last) <u>Gibbs</u>	OF DEATH: <u>November 17 19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>1883</u>
9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Unknown</u>
13. FATHER'S NAME: <u>Thomas Gibbs</u>		14. MOTHER'S MAIDEN NAME: <u>Maggie Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS: <u>Mr. Ed. Bell</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.0</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Arteriosclerotic Heart Disease</u>			<u>3 yrs</u>
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>11/12</u> , 19 <u>55</u> to <u>11/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>55</u> , and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>H. H. [Signature]</u>		DATE SIGNED <u>11/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>11-19-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Greenbackville Cemetery</u>		<u>Greenbackville, Va</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>11-25-55</u>		<u>Mary W. Holloray, Wm. H. Salinger, Chincoteague, Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 28 1955

RECEIVED

11351

## CERTIFICATE OF DEATH

11366

Reg. Dist. No. 281

## INSTRUCTIONS

1  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>12</u> TOWN <u>Salisbury, Maryland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mechanicsville, Maryland</u> <u>18X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>James</u> <u>Roland</u> <u>Goldsborough</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov.</u> <u>24</u> <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>1903</u>		<b>9. AGE last birthday</b> <u>52</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>unk</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>James Thomas Goldsborough</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucy Ann Farrell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>unk</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unk</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>IMMEDIATE CAUSE (A)</b> <u>592X</u> <u>Uremia</u>						<u>1 week</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Chronic glomerulo nephritis</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Hypertensive C-V-D</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>11-3</u> , <u>1955</u> , to <u>11-24</u> , <u>1955</u> ; that I last saw the deceased alive on <u>11-24</u> , <u>1955</u> , and that death occurred at <u>2:50 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
M. D.							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>11/28/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Joseph Cem.</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Morganza, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>11/28/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>ADDRESS</b> <u>Leonardtwn, Md.</u>	

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Signature of Registrar

Signature of Physician

RECEIVED  
BUREAU V. S.  
DEC 2 1955

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled in by the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11367

11352

## CERTIFICATE OF DEATH

Dr. Wm Smith

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY OR TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>Allen</u>		1	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>DIANNE</u> (First) <u>RAE</u> (Middle) <u>Gunby</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>November</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 2, 1954</u>	9. AGE last birthday <u>1</u> yrs. <u>10</u> Months <u>11</u> Days	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hospital- Salisbury Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Miles Ernest Gunby</u>				14. MOTHER'S MAIDEN NAME <u>Constance R. Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Miles E. Gunby (Father) Allen, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>759.3 IMMEDIATE CAUSE (A) <u>Pneumonia</u></u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Multiple Congenital Deformities</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Hydrocephalus, Epina Bifida, c</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>paralysis of B.B. + lower Ext.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/12</u> , 19 <u>55</u> , to <u>11/13</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>11/13</u> , 19 <u>55</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm B. Smith M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>11-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FILED BY REGISTRAR <u>Nov. 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

1955 CERTIFICATE OF DEATH

Form 1000, Rev. 1-55

Dr. W. Smith

1. Name of deceased Miss Ernest Gandy		2. Sex Female		3. Age 45	
4. Date of death Nov 15 1955		5. Time of death 10:00 AM		6. Place of death Home	
7. Cause of death Heart disease		8. Manner of death Natural		9. Signature of physician Dr. W. Smith	
10. Signature of registrar J. A. Smith		11. Signature of informant Mrs. Gandy		12. Signature of funeral director J. A. Smith	
13. Signature of medical examiner J. A. Smith		14. Signature of coroner J. A. Smith		15. Signature of health officer J. A. Smith	

RECEIVED

NOV 15 1955

RECEIVED

RECEIVED

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11368

11353

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND <u>11</u>		STATE <u>Virginia</u> COUNTY <u>Accomack</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 TOWN Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greenbackville</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <u>Virginia</u> (Middle) <u>B</u> (Last) <u>Hart</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>11</u> <u>17</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Mar 27, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>20</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Franklin W. Colona</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Baylis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>Harry J. S. Hart</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hyperthermia</u> DUE TO						<u>36 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Cerebral Vascular Accident</u> DUE TO						<u>74 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Cardio Vascular Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture Right Femoral Neck</u>							
19A. DATE OF OPERATION: <u>11-1-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Non-Displaced Fracture, Rt Femoral Neck</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Patient Fell Down.</u>			
22. I hereby certify that I attended the deceased from <u>10-28, 1955</u> , to <u>11-17, 1955</u> that I last saw the deceased alive on <u>11-17</u> , 1955, and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank E. Poole, M.D.</u>		ADDRESS <u>M. D. Salisbury, Md.</u>		DATE SIGNED <u>11-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>11-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Union Memorial</u>		LOCATION (City, town, or county) (State) <u>Greenbackville, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-18-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Mrs. N. A. Shields</u>		ADDRESS <u>New Church, Va.</u>	

RECEIVED

NOV 21 1955

BUREAU V. 2

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11354

## CERTIFICATE OF DEATH

12496

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>12 Salisbury</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		<i>12</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>05</i>				STREET ADDRESS (If rural give location) <i>516 Booth St</i>		<i>1</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>George</i> (First) <i>Hearn</i> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>11 30 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>1907</i>	9. AGE last birthday <i>48</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Salisbury md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Marion Hearn</i>				14. MOTHER'S MAIDEN NAME <i>Sellie Dixon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>James Hearn</i>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A) <i>Cerebral Apoplexy</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>				<i>10 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X (C) <i>Chronic Heart Disease</i>				<i>2</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes</i>				<i>2 years</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 25</i> , 19 <i>55</i> , to <i>Nov 30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Nov 29</i> , 19 <i>55</i> , and that death occurred at <i>1:30</i> M, from the causes and on the date stated above.							
SIGNATURE <i>G. Herbert Sembley</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury md</i>		DATE SIGNED <i>11/30/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		DATE THEREOF <i>12-5-55</i>		NAME OF CEMETERY OR CREMATORY <i>Houston Cem</i>		LOCATION (City, town, or county) (State) <i>Salisbury md</i>	
24. REC'D BY REGISTRAR <i>JFC 8</i>		REGISTRAR'S SIGNATURE <i>Mary J. Galloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Brook M. Coak</i>		ADDRESS	
DATE <i>1955</i>							

CERTIFICATE OF DEATH

REG. DIST. NO.

DEATH CERTIFICATE NUMBER

DEATH NO.

DATE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

DATE OF DEATH

1907

1907

1907

Debbie Taylor  
former steamer

Maurice Kerner

BUREAU V. S.

DEC 8 1955

RECEIVED

12-222 Kerner  
12-222 Kerner

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11369

11383

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Maryland</i> COUNTY <i>Wicomico</i>	
CITY (if outside corporate limits, write RURAL or give nearest town) <i>Willards</i>	LENGTH OF STAY (in this place) <i>life</i>	CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Willards</i>	<i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>RFD.</i>	<i>1</i>
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Randolph Herban Scorn</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Nov. 18 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>Jan 4 1915</i>
9. AGE last birthday: <i>40</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>farmer</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Keams Scorn</i>		14. MOTHER'S MAIDEN NAME: <i>Lola Wilkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <i>214-32-6582</i>	
17. INFORMANT & ADDRESS: <i>Mrs Randolph Scorn Willards</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary thrombosis</i>		<i>30 minutes</i>	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11-18</i> , 1955, to <i>11-18</i> , 1955, that I last saw the deceased alive on <i>11-18</i> , 1955, and that death occurred at <i>100</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Frank R Lewis</i>		ADDRESS <i>Willards Md.</i> DATE SIGNED <i>11-19-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11/21/55</i>	
NAME OF CEMETERY OR CREMATORY <i>New Hope</i>		LOCATION (City, town, or county) (State) <i>Willards Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11-22-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	
24. FUNERAL DIRECTOR <i>Peter Whaley Selby, Del.</i>		ADDRESS	

BUREAU V. S.

NOV 25 1955

RECEIVED



1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11370

11355

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 9-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>		LENGTH OF STAY (in this place) <u>3 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shaptown</u>		X	
TOWN				TOWN		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>San Domingo</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>George Roosevelt Henry</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>November 3- 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>December 7 1909</u>	
9. AGE last birthday <u>47</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Cutter</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Henry</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Elmira A. Henry, Mardela Springs Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>General Sepsis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Multiple Ulcerations</u>				" " <u>approx 5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Sickle Cell Anemia</u>				<u>known 6 mos</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hepatic Insufficiency</u>							
19a. DATE OF OPERATION <u>292.6</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/14/1955</u> to <u>11/3/1955</u> , that I last saw the deceased alive on <u>11/3/55</u> and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Stanley Schwane</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>11/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 6 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Shaptown Maryland</u>	
24. REC'D BY REGISTRAR <u>11-6-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u>		ADDRESS <u>San Federalburg, Md.</u>	

# CERTIFICATE OF DEATH

REG. DIST. NO.

REG. DIST. NO. OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STATE OF

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

BUREAU V. 2

NOV 17 1955

RECEIVED

NOTATION

1. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

2. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

3. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

4. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

5. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

6. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

7. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

8. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

9. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

10. This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

1  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11356 CERTIFICATE OF DEATH

11372

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Kent</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>2 1/2 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Chestertown</b>		<b>14-37-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Deer's Head State Hospital</b>				STREET ADDRESS (If rural give location) <b>402 Calvert Street</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>John T. Iler</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 9 1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Separated</b>	<b>8. DATE OF BIRTH</b> <b>12/25/1888</b>		<b>9. AGE last birthday</b> <b>66 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-12-145874</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital records</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>332X</b> IMMEDIATE CAUSE (A) <b>Cerebral thrombosis</b>						<b>1 hour</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>arteriosclerosis, general and cerebral</b>						<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arteriosclerotic cardiovascular disease</b>						<b>?</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Mar. 20</b> , 19 <b>53</b> , to <b>Nov. 9</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Nov. 8</b> , 19 <b>55</b> , and that death occurred at <b>2:50A</b> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Dr. V. Juerman</b> <b>V. Juerman, M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Deer's Head State Hospital</b> <b>Salisbury, Maryland</b>		<b>DATE SIGNED</b> <b>11/9/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11-12-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Acres Cem</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11-15-55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary W. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Booker M. [unclear]</b>		<b>ADDRESS</b> <b>Salisbury</b>	

CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL RESIDENT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT HOME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT HOME OF DECEASED

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CAUSE OF DEATH

PERMANENT HOME OF DECEASED

LOCAL RESIDENT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT HOME OF DECEASED

DATE OF BIRTH

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9-15-15 14 11 11

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1955

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Green House Can be destroyed

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11373

## 11357 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 10/27/55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Berlin</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>05</u> <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>Bay Street</u>		✓	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>John</u> (Middle) <u>Edward</u> (Last) <u>Jarman</u>				(Month) <u>11</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 15, 1864</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Jarman</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Coard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4</u> No		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Clinton &amp; Edward Jarman (Sons) BERLIN, MD.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>002X</u> <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>10/27/55</u> , 19....., <b>to</b> <u>11/12/55</u> , 19....., <b>that I last saw the deceased</b> <b>alive on</b> <u>11/12/55</u> , 19....., <b>and that death occurred at</b> <u>12:35</u> AM, <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Lee L. Lawry</u> <b>M.D.</b> <u>Fruitland, Md.</u> <b>DATE SIGNED</b> <u>11/12/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. REC'D BY REGISTRAR <u>11/15/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Burbage Funeral Home, Berlin, Md.</u>		ADDRESS	



RECEIVED

1  
This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Bureau of Health Statistics of the Maryland State Department of Health, Baltimore, Md.  
Witness my hand and the seal of the said Department at Baltimore, Md., this 11th day of June, 1952.

1105 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 11/16/1916		6. PLACE OF BIRTH Jackson, Mississippi	
7. MARITAL STATUS Single		8. OCCUPATION Minister of the Gospel		9. CAUSE OF DEATH Suicide	
10. DATE OF DEATH 6/4/52		11. PLACE OF DEATH Memphis, Tennessee		12. SIGNATURE OF DECEASED JAMES EARL RAY	
13. SIGNATURE OF PHYSICIAN DR. J. H. HARRIS		14. SIGNATURE OF MINISTER DR. J. H. HARRIS		15. SIGNATURE OF CORONER DR. J. H. HARRIS	
16. SIGNATURE OF JURY DR. J. H. HARRIS		17. SIGNATURE OF JURY DR. J. H. HARRIS		18. SIGNATURE OF JURY DR. J. H. HARRIS	
19. SIGNATURE OF JURY DR. J. H. HARRIS		20. SIGNATURE OF JURY DR. J. H. HARRIS		21. SIGNATURE OF JURY DR. J. H. HARRIS	
22. SIGNATURE OF JURY DR. J. H. HARRIS		23. SIGNATURE OF JURY DR. J. H. HARRIS		24. SIGNATURE OF JURY DR. J. H. HARRIS	
25. SIGNATURE OF JURY DR. J. H. HARRIS		26. SIGNATURE OF JURY DR. J. H. HARRIS		27. SIGNATURE OF JURY DR. J. H. HARRIS	
28. SIGNATURE OF JURY DR. J. H. HARRIS		29. SIGNATURE OF JURY DR. J. H. HARRIS		30. SIGNATURE OF JURY DR. J. H. HARRIS	
31. SIGNATURE OF JURY DR. J. H. HARRIS		32. SIGNATURE OF JURY DR. J. H. HARRIS		33. SIGNATURE OF JURY DR. J. H. HARRIS	
34. SIGNATURE OF JURY DR. J. H. HARRIS		35. SIGNATURE OF JURY DR. J. H. HARRIS		36. SIGNATURE OF JURY DR. J. H. HARRIS	
37. SIGNATURE OF JURY DR. J. H. HARRIS		38. SIGNATURE OF JURY DR. J. H. HARRIS		39. SIGNATURE OF JURY DR. J. H. HARRIS	
40. SIGNATURE OF JURY DR. J. H. HARRIS		41. SIGNATURE OF JURY DR. J. H. HARRIS		42. SIGNATURE OF JURY DR. J. H. HARRIS	
43. SIGNATURE OF JURY DR. J. H. HARRIS		44. SIGNATURE OF JURY DR. J. H. HARRIS		45. SIGNATURE OF JURY DR. J. H. HARRIS	
46. SIGNATURE OF JURY DR. J. H. HARRIS		47. SIGNATURE OF JURY DR. J. H. HARRIS		48. SIGNATURE OF JURY DR. J. H. HARRIS	
49. SIGNATURE OF JURY DR. J. H. HARRIS		50. SIGNATURE OF JURY DR. J. H. HARRIS		51. SIGNATURE OF JURY DR. J. H. HARRIS	
52. SIGNATURE OF JURY DR. J. H. HARRIS		53. SIGNATURE OF JURY DR. J. H. HARRIS		54. SIGNATURE OF JURY DR. J. H. HARRIS	
55. SIGNATURE OF JURY DR. J. H. HARRIS		56. SIGNATURE OF JURY DR. J. H. HARRIS		57. SIGNATURE OF JURY DR. J. H. HARRIS	
58. SIGNATURE OF JURY DR. J. H. HARRIS		59. SIGNATURE OF JURY DR. J. H. HARRIS		60. SIGNATURE OF JURY DR. J. H. HARRIS	
61. SIGNATURE OF JURY DR. J. H. HARRIS		62. SIGNATURE OF JURY DR. J. H. HARRIS		63. SIGNATURE OF JURY DR. J. H. HARRIS	
64. SIGNATURE OF JURY DR. J. H. HARRIS		65. SIGNATURE OF JURY DR. J. H. HARRIS		66. SIGNATURE OF JURY DR. J. H. HARRIS	
67. SIGNATURE OF JURY DR. J. H. HARRIS		68. SIGNATURE OF JURY DR. J. H. HARRIS		69. SIGNATURE OF JURY DR. J. H. HARRIS	
70. SIGNATURE OF JURY DR. J. H. HARRIS		71. SIGNATURE OF JURY DR. J. H. HARRIS		72. SIGNATURE OF JURY DR. J. H. HARRIS	
73. SIGNATURE OF JURY DR. J. H. HARRIS		74. SIGNATURE OF JURY DR. J. H. HARRIS		75. SIGNATURE OF JURY DR. J. H. HARRIS	
76. SIGNATURE OF JURY DR. J. H. HARRIS		77. SIGNATURE OF JURY DR. J. H. HARRIS		78. SIGNATURE OF JURY DR. J. H. HARRIS	
79. SIGNATURE OF JURY DR. J. H. HARRIS		80. SIGNATURE OF JURY DR. J. H. HARRIS		81. SIGNATURE OF JURY DR. J. H. HARRIS	
82. SIGNATURE OF JURY DR. J. H. HARRIS		83. SIGNATURE OF JURY DR. J. H. HARRIS		84. SIGNATURE OF JURY DR. J. H. HARRIS	
85. SIGNATURE OF JURY DR. J. H. HARRIS		86. SIGNATURE OF JURY DR. J. H. HARRIS		87. SIGNATURE OF JURY DR. J. H. HARRIS	
88. SIGNATURE OF JURY DR. J. H. HARRIS		89. SIGNATURE OF JURY DR. J. H. HARRIS		90. SIGNATURE OF JURY DR. J. H. HARRIS	
91. SIGNATURE OF JURY DR. J. H. HARRIS		92. SIGNATURE OF JURY DR. J. H. HARRIS		93. SIGNATURE OF JURY DR. J. H. HARRIS	
94. SIGNATURE OF JURY DR. J. H. HARRIS		95. SIGNATURE OF JURY DR. J. H. HARRIS		96. SIGNATURE OF JURY DR. J. H. HARRIS	
97. SIGNATURE OF JURY DR. J. H. HARRIS		98. SIGNATURE OF JURY DR. J. H. HARRIS		99. SIGNATURE OF JURY DR. J. H. HARRIS	
100. SIGNATURE OF JURY DR. J. H. HARRIS		101. SIGNATURE OF JURY DR. J. H. HARRIS		102. SIGNATURE OF JURY DR. J. H. HARRIS	

RECEIVED  
Bureau of Health Statistics  
June 11/1952  
Bureau of Health Statistics

BUREAU V. S.

11/15-1952



11358

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Worcester</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill</i> <i>23x-2</i>			
12 TOWN <i>Salisbury</i>				STREET ADDRESS (If rural give location) <i>R. R #2</i>			
82 HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>November 28 1955</i>			
<i>Ruben Johnson</i>							
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>✓</i>	8. DATE OF BIRTH: <i>Oct. 10, 1888</i>	9. AGE last birthday: <i>67</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farming</i>		11. BIRTHPLACE (State or foreign country): <i>Atlanta, Ga</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Unknown</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Hospital Record</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE				(A) <i>Uremia</i>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <i>Hydronephrosis</i>			
				DUE TO			
				(C) <i>Carcinoma Prostate</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Arteriosclerosis, Hypertension</i>			
19A. DATE OF OPERATION: <i>11-21-55</i>				19B. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11-21-55</i> to <i>11-28-55</i> , that I last saw the deceased alive on <i>11-28-55</i> , and that death occurred at <i>8:21 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>H. Herbert Sewbley</i>				ADDRESS <i>Salisbury, Md</i>		DATE SIGNED <i>11/29/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <i>12-5-55</i>		NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		LOCATION (City, town, or county) (State) <i>Snow Hill, Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12-2-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Hallonay</i>		24. FUNERAL DIRECTOR <i>Clay E. Hennig</i>		ADDRESS <i>Snow Hill, Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 5 1955

BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11384

## CERTIFICATE OF DEATH

11375

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Tyaskin</u>		<u>Lifetime</u>		TOWN <u>Tyaskin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>THEODORE</u> (Middle) <u>JONES</u> (Last)				<u>Nov. 29</u> 19 <u>55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>		
<u>male</u>	<u>white</u>	<u>married</u>	<u>March 24, 1872</u>	<u>83</u> yrs.	Months <u>8</u>	Days <u>5</u>	Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Farmer</u>		<u>Own farm</u>		<u>Tyaskin, Md.</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Wesley Jones</u>				<u>Adeline Porter</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u></u>		<u>Wilmer Jones, Nanticoke, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>331X IMMEDIATE CAUSE (A)</b>						<u>Cerebral hemorrhage</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>						<u>1 month</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)</b>						<u>10 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>3 weeks</u>	
<u>Inanition</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>7/12</u> <u>1950</u> , <b>to</b> <u>11/29</u> <u>1955</u> , <b>that I last saw the deceased alive on</b> <u>11/29</u> <u>1955</u> , <b>and that death occurred at</b> <u>11:15 p.m.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Richard H. Saunders</u> M.D.				<u>Nanticoke Md.</u>		<u>12/2/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>12/2/55</u>		<u>St. Marys Cemetery</u>		<u>Tyaskin Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>DEC 5 1955</u>		<u>Mary H. Holloway</u>		<u>Harold L. Messick</u>		<u>Bivolve, Md.</u>	
<b>DATE</b>							

# CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death (Print or write full name)

8. Nature of disease or injury

9. Duration of disease or injury

10. Name of physician

11. Name of attending nurse

12. Name of undertaker

13. Name of funeral home

14. Name of cemetery

15. Name of burial place

16. Name of interment place

17. Name of crematorium

18. Name of crematory

19. Name of crematorium

20. Name of crematory

21. Name of crematorium

22. Name of crematory

23. Name of crematorium

24. Name of crematory

25. Name of crematorium

26. Name of crematory

27. Name of crematorium

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31. Name of crematorium

32. Name of crematory

33. Name of crematorium

34. Name of crematory

35. Name of crematorium

36. Name of crematory

37. Name of crematorium

38. Name of crematory

BUREAU V. S.

DEC 5 1955

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DEC 5 1955

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11385 **CERTIFICATE OF DEATH**

11376

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Wetipquin</b>		LENGTH OF STAY (in this place) <b>Most of life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Wetipquin</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - Wetipquin</b>				STREET ADDRESS (If rural give location) <b>Route # 1 Quantico, Md.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>Thomas Henry Joseph</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 - 5 - 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>About 1883</b>	<b>9. AGE last birthday</b> <b>72 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wetipquin, Wicomico Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Alexander Joseph</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elenora Hull</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Lucy Joseph, Quantico, Md. Rt. #1</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
IMMEDIATE CAUSE (A) <b>Cancer of Stomach</b>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>arteriosclerosis</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 14, 19 55, to Nov 4, 19 55, that I last saw the deceased alive on Nov 4, 19 55, and that death occurred at 4:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Charles E. Smith</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Hebron Md</b>		<b>DATE SIGNED</b> <b>Nov 6, 55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11-9-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Odd Fellows Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Wetipquin, Wicomico Co. Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary W. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mary A. Stewart</b>		<b>ADDRESS</b> <b>Stewart Funeral Home, Salisbury, Md.</b>	
<b>DATE</b> <b>11-9-55</b>							

CERTIFICATE OF DEATH

Reg. No. 100

LOCAL HEALTH OFFICE TO BE COMPLETED

Deceased Name: *Harriet*

Age: *40*

Sex: *Female*

Place of Birth: *Harriet*

Place of Death: *Harriet*

Time of Death: *11:00 AM - 11:30 AM*

Cause of Death: *Heart Disease*

Immediate Cause: *Heart Disease*

Year: *1955*

Month: *10*

Day: *10*

Hour: *11*

Minute: *15*

Year: *1955*

Month: *10*

Day: *10*

Hour: *11*

Minute: *15*

Second: *00*

Third: *00*

Fourth: *00*

Fifth: *00*

Sixth: *00*

Seventh: *00*

Eighth: *00*

Ninth: *00*

Tenth: *00*

Eleventh: *00*

Twelfth: *00*

Thirteenth: *00*

Fourteenth: *00*

Fifteenth: *00*

Sixteenth: *00*

Seventeenth: *00*

Eighteenth: *00*

Nineteenth: *00*

Twentieth: *00*

Twenty-first: *00*

Twenty-second: *00*

Twenty-third: *00*

Twenty-fourth: *00*

Twenty-fifth: *00*

Twenty-sixth: *00*

Twenty-seventh: *00*

Twenty-eighth: *00*

Twenty-ninth: *00*

Thirtieth: *00*

Thirty-first: *00*

Thirty-second: *00*

Thirty-third: *00*

Thirty-fourth: *00*

Thirty-fifth: *00*

Thirty-sixth: *00*

Thirty-seventh: *00*

Thirty-eighth: *00*

Thirty-ninth: *00*

Fortieth: *00*

Forty-first: *00*

Forty-second: *00*

Forty-third: *00*

Forty-fourth: *00*

Forty-fifth: *00*

Forty-sixth: *00*

Forty-seventh: *00*

Forty-eighth: *00*

Forty-ninth: *00*

Fiftieth: *00*

Fifty-first: *00*

Fifty-second: *00*

Fifty-third: *00*

Fifty-fourth: *00*

Fifty-fifth: *00*

Fifty-sixth: *00*

Fifty-seventh: *00*

Fifty-eighth: *00*

Fifty-ninth: *00*

Sixtieth: *00*

Sixty-first: *00*

Sixty-second: *00*

Sixty-third: *00*

BUREAU V. 8

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11359

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11377

Dr. Gray

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 82 <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>633 Germania Circle</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>ASHER R. LAYFIELD</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>NOV. 10 th 19 55</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 31, 1879</b>	9. AGE last birthday <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>9</b>		IF UNDER 24 HRS. Hours <b>9</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer on Farm - Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Handy W. Layfield</b>				14. MOTHER'S MAIDEN NAME <b>Timmon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Paul R. Layfield (Son) R.D.# Willards Maryland</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) <b>Cerebral Thromboses</b>						10 days	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Senile generalized arteriosclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct. 31, 19 55</b> , to <b>Nov. 10, 19 55</b> , that I last saw the deceased alive on <b>Nov. 10, 19 55</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>William D Gray</b>				ADDRESS (Street, city, town, state) <b>M.D. Camden Ave. Salisbury, Maryland</b>		DATE SIGNED <b>Nov. 12 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Nov. 14, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. RECD BY REGISTRAR DATE <b>Nov. 14, 1955</b>		REGISTRAR'S SIGNATURE <b>Mary Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1955

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Place of registration	

BUREAU V. S.

NOV 14 1955

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NOV 14 1955

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NOV 14 1955  
BALTIMORE, MARYLAND  
STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
RECEIVED

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11360

## CERTIFICATE OF DEATH

11378

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Del.</i>		COUNTY <i>Sussex</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place) <i>3 wks.</i>		CITY (If outside corporate limits, write RURAL, and give nearest town) <i>Selbyville</i>		<i>46x3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Hill Pnt. Sani.</i>				STREET ADDRESS <i>church st.</i>		✓	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>FURMAN</i> (First) <i>B.</i> (Middle) <i>LONG</i> (Last)				<b>4. DATE OF DEATH</b> (Month) <i>Nov.</i> (Day) <i>2</i> (Year) <i>1955</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>		8. DATE OF BIRTH <i>Jan. 26, 1876</i>	
				9. AGE last birthday <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Frankford, Del.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Eber Long</i>				14. MOTHER'S MAIDEN NAME <i>Luthenia Lockwood</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>222-05-0701</i>		17. INFORMANT & ADDRESS <i>Asher Long - Millsboro, Del.</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
442x IMMEDIATE CAUSE (A) <i>Cardiovascular renal disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cerebral Leukemia</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10/29</i> , 19 <i>55</i> , to <i>11/2</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11-1</i> , 19 <i>55</i> , and that death occurred at <i>5:15 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Phyllis L. Lundy</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury Md</i>		DATE SIGNED <i>11-2-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Nov. 4, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Red Mens</i>		LOCATION (City, town, or county) (State) <i>Selbyville Del.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Henry St. Watson</i>		ADDRESS <i>Pocomoke City, Md.</i>	
DATE <i>11-4-55</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <b>Rural Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Salisbury Rural</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D. # 4 Johnson Road</b>		(D.O.A. at Hospital)		STREET ADDRESS (If rural, give location) <b>R.D. # 4</b>			
3. NAME OF DECEASED: (First) <b>CECIL</b>		(Middle) <b>WILLIAM</b>		(Last) <b>MILLER</b>		4. DATE OF DEATH (Month) <b>NOV.</b> (Day) <b>8th</b> (Year) <b>19 55</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>July 3, 1946</b>		9. AGE last birthday: <b>9</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>School Student</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>None</b>		11. BIRTHPLACE (State or foreign country): <b>Salisbury Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Benjamin Samuel Miller</b>				14. MOTHER'S MAIDEN NAME: <b>Stella Jean Bostic</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Mr. Benjamin S. Miller (Father) R.D. # 4 Salisbury, Maryland</b>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<b>1 hour</b>	
Immediate cause <b>813 X</b>		(a) <b>Fractured Skull</b>			
Antecedent cause(s)		DUE TO <b>Crushed Chest</b>			
Diseases or conditions, if any, giving rise to the above cause		DUE TO			
stating underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, place bldg, etc., INJURY <b>Street</b> )		21c. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>MD</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>11 8 55 AM</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Struck by auto while riding bike</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>Earl Royer</b>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Nov. 10 1955</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Nov. 11, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		(State)			
DATE REC'D BY LOCAL REG. <b>11-10-55</b>		REGISTRAR'S SIGNATURE <b>Mary T. Holloway</b>		24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

NOV 17 1955

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## Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Wicomico</b>	<b>MARYLAND</b>	STATE <b>Maryland</b>	COUNTY <b>Wicomico</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>	LENGTH OF STAY (in this place) <b>2 mons.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Hill Private Sanit.</b>		STREET ADDRESS (If rural give location) <b>308 E. Willian St.,</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>MARIA THORINGTON MITCHELL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11 1 19 55</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 28, 1869</b>
9. AGE last birthday <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William W. Thorington</b>		14. MOTHER'S MAIDEN NAME <b>Susan Conway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.) (If Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT & ADDRESS <b>Miss Marian Nock</b>		18. Same	
19. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>331X IMMEDIATE CAUSE (A) Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSE(S) DUE TO <b>Hypertension. Cerebral arteriosclerosis</b>		<b>Years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>Generalized atherosclerosis</b>		<b>Years</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic nephritis</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/2</b> , 19 <b>55</b> , to <b>10/31</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>10/31</b> , 19 <b>55</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city, town, state) <b>211 Maryland Ave, Salisbury Md</b>	
M.D. <b>[Signature]</b>		DATE SIGNED <b>11/2/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>11/4/1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Md</b>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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*(Signature)*

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The Hill &amp; Johnson Co.

Reg. Dist. No.....

## INSTRUCTIONS

VS A15C 1.55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased John W. Sayers		2. Sex Male		3. Age 65	
4. Date of death Nov. 18, 1955		5. Time of death 10:15 AM		6. Place of death Home	
7. Cause of death Myocardial infarction		8. Manner of death Natural		9. Signature of physician [Signature]	
10. Signature of registrar [Signature]		11. Date of registration Nov. 21, 1955		12. Office of registration Baltimore, Md.	

BUREAU V. S.

NOV 21 1955

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NOV 21 1955  
BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11364 **CERTIFICATE OF DEATH**

11382

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Queen Anne's</b>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		LENGTH OF STAY (in this place) <b>38 days</b>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>D Centreville</b>		<b>17X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>91 Deer's Head State Hospital</b>				STREET ADDRESS (If rural give location) <b>✓</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>William</b>		(Middle) <b>W</b>		(Last) <b>Potter</b>		(Month) <b>Nov.</b> (Day) <b>12</b> (Year) <b>19 55</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>2/22/1874</b>	<b>9. AGE last birthday</b> <b>81 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cecilton, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William S. Potter</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Caroline Reeves</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Records</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>332X IMMEDIATE CAUSE (A)</b> <b>Cerebral thrombosis</b>						<b>4 days</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arteriosclerosis - general</b>						<b>?</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Ca. of the right lung</b>						<b>?</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Oct. 5, 19 55</b> , to <b>Nov. 12, 19 55</b> , that I last saw the deceased alive on <b>Nov. 12, 19 55</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>L.V. Maldve, M.D.</b>		<b>ADDRESS</b> (Street, city, town, state) <b>Deer's Head State Hospital, Salisbury, Maryland</b>		<b>DATE SIGNED</b> <b>11/12/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 15, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wye Mills Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Wye Mills, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary D. Holloman</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James H. Batten, Jr.</b>		<b>ADDRESS</b> <b>Centreville, Maryland</b>	
<b>DATE</b> <b>11-16-55</b>							



CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Sex

Color

Marital Status

Occupation

Education

Religion

Usual Residence

Place of Death

Cause of Death

Manner of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Mayor

Signature of Town Clerk

Signature of Justice of the Peace

Signature of Notary Public

Signature of Minister of the Gospel

Signature of Minister of the Gospel

Signature of Minister of the Gospel

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11383

## 11386 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> TOWN <b>Quantico</b>		LENGTH OF STAY (in this place) <b>Most of life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Quantico</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>02 At home - Quantico</b>				STREET ADDRESS (If rural give location) <b>Route # 1</b>		<b>1</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Charles</b> (First) <b>Price</b> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 - 18 - 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>About 1877</b>	<b>9. AGE last birthday</b> <b>78 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Quantico, Wicomico Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles Price</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Horsey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. G. Ernest Price, Quantico, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>422.2 IMMEDIATE CAUSE (A)</b> <b>Chronic Myocarditis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>July 14, 1955</b> , to <b>Nov 18, 1955</b> , that I last saw the deceased alive on <b>Nov 14, 1955</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>William E. Smith</b> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Holston M.</b>		<b>DATE SIGNED</b> <b>11-19-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11-22-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Church Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Quantico, Wicomico Co. Md.</b>	
<b>24. REC'D BY REGISTRAR</b> DATE <b>11-22-55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary W. Holloman</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mary A. Stewart</b> ADDRESS <b>Stewart Funeral Home Salisbury, Md.</b>			

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11365 **CERTIFICATE OF DEATH**Reg. Dist. No. **11384**

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>12 Salisbury</b>		LENGTH OF STAY (in this place) <b>16 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>23X-2 Berlin</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>82 Peninsula General Hospital</b>				STREET ADDRESS (If rural give location) <b>Route # 1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Elizabeth Provide Purnell</b>				<b>4. DATE OF DEATH</b> <b>11 - 20 - 19 55</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>A.A.</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>		8. DATE OF BIRTH <b>11-21-1902</b>	
9. AGE last birthday <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>29</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cook</b>		11. BIRTHPLACE (State or foreign country) <b>Berlin, Worcester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Purnell</b>				14. MOTHER'S MAIDEN NAME <b>Julia Whaley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-4584</b>		17. INFORMANT & ADDRESS <b>Jacob Purnell, Berlin, Md., Rt. # 1</b>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>441X IMMEDIATE CAUSE (A) Cordiac Failure</b>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>Hypertensive Heart Disease</b>							
(C) <b>Malignant Hypertension</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <b>Nov 15, 1955</b> , to <b>Nov 20, 1955</b> , that I last saw the deceased alive on <b>Nov 20, 1955</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above <b>11/23/55</b> <b>SIGNATURE</b> <b>Mary W. Holloway</b> <b>M.D.</b> <b>ADDRESS</b> <b>Stewart Funeral Home</b> <b>DATE SIGNED</b> <b>Salisbury, Md.</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>11-24-55</b>		NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		LOCATION (City, town, or county) (State) <b>Berlin, Worcester Co., Md.</b>	
24. REC'D BY REGISTRAR DATE <b>11-23-55</b>		REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Mary A. Stewart</b>		ADDRESS <b>Stewart Funeral Home</b>	

CERTIFICATE OF DEATH

NOV 28 1955

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John F. Kennedy		Male		35		11-21-1920		Boston, Mass.		Boston, Mass.		Heart Disease		Boston, Mass.		11-28-1955		10:00 AM		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Previous Operations		Previous Injuries		Previous Habits		Previous Occupations		Previous Residences		Previous Deaths		Previous Burials		Previous Cremations	
None		High School		Married		None		None		None		None		None		None		None		None		None	
Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist	
Heart Disease		Boston, Mass.		11-28-1955		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

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BUREAU V. S.

11366

## CERTIFICATE OF DEATH

11385

Dr. Beardsley

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY **Wicomico** MARYLANDCITY (If outside corporate limits, write RURAL  
OR end give nearest town)12 TOWN **Salisbury**LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

82 Pen. Gen. Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Wicomico**

CITY (If outside corporate limits, write RURAL and give nearest town)

CITY OR TOWN **Pittsville** X

STREET ADDRESS (If rural give location)

In Village /

3. NAME OF DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

GORMAN

CLEVELAND

RAYNE

## 4. DATE (Month)

(Day)

(Year)

OF DEATH **Nov.****3 rd** 19 **55**

## 5. SEX

**Male**

## 6. COLOR OR RACE

**White**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

**Widowed**

## 8. DATE OF BIRTH

**Aug 31, 1886**

## 9. AGE last birthday

**69** yrs.

## IF UNDER 1 YEAR

Months **2**Days **2**

## IF UNDER 24 HRS.

Hours **2** Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Owner of Auto Co.**

## 10b. KIND OF BUSINESS OR INDUSTRY

**Ford Dealer**

## 11. BIRTHPLACE (State or foreign country)

**R.D. # Willards Maryland**

## 12. CITIZEN OF WHAT COUNTRY?

**USA**

## 13. FATHER'S NAME

**Joel Rayne**

## 14. MOTHER'S MAIDEN NAME

**Rosena Baker**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)**Unk**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT'S ADDRESS

**Miss Martha Ann Rayne (Daughter)  
Pittsville, Maryland**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 420.1 IMMEDIATE CAUSE (A)

(A)

**myocardial infarction**

## ANTECEDENT CAUSE(S)

DUE TO

**coronary thrombosis**

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE

DUE TO

## STATING UNDERLYING CAUSE LAST.

DUE TO

**coronary atherosclerosis**

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

**5 days****3 days**21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

## 20. AUTOPSY?

YES ☒ NO ☐22. I hereby certify that I attended the deceased from **Apr 35**, 19 **55**, to **11-3**, 19 **55**, that I last saw the deceased alive on **11-3**, 19 **55**, and that death occurred at **4:00 A.** M, from the causes and on the date stated above.

SIGNATURE

**Dr. Beardsley**

ADDRESS (Street, city, town, state)

DATE SIGNED

**M.D. East Church St Salisbury, Maryland Nov. 4/55**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

**Burial****Nov. 6-1955****Pittsville Cemetery****Pittsville, Maryland**

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

DATE

**Mary J. Holloway****HOLLOWAY & COMPANY****SALISBURY MARYLAND**

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



11885

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

# CERTIFICATE OF DEATH

Form No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		35		Jan 1, 1910		New York City		Natural		Heart Disease		Jan 15, 1945		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Previous Deaths		Previous Injuries		Previous Operations		Previous Hospitalizations		Previous Discharges		Previous Burials		Previous Cremations	
Teacher		High School		Married		None		None		None		None		None		None		None		None		None	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 15, 1945		10:00 AM		Home		Dr. J. Smith		J. Doe		Jan 15, 1945		10:00 AM		Home		Dr. J. Smith		J. Doe		Jan 15, 1945		10:00 AM	

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11367

## CERTIFICATE OF DEATH

11386

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		13 Hrs.		OR TOWN <u>Tyaskin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>						1	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ROBERTSON</u>				<u>November 9 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>newborn</u>	<u>November 9, 1953</u>	<u>-</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Willie Randall Robertson</u>				<u>Emma Jean Downing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>-</u>		<u>Willie Robertson, White Haven, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
IMMEDIATE CAUSE (A) <u>Eng. Cordiac Decompensation</u>						<u>6 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Erthroblastosis Fetalis</u>						<u>13 hr 7 min</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						(State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 9, 1955</u> , to <u>Nov 9, 1955</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>55</u> , and that death occurred at <u>7:35</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>11/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/10/55</u>		<u>Memorial Park Cem</u>		<u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-10-55</u>		<u>Mary W. Holloway</u>		<u>Cornelius D. Messick, Brooke, Md.</u>			

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 113C 1-55 10M

# CERTIFICATE OF DEATH

Form 100-10-1

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

TO BE FILLED BY THE REGISTRAR

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		DATE OF REGISTRATION [Faint text]	

BUREAU V. S.

NOV 17 1955

RECEIVED

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12514

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Eden</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Eden</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home- Eden, Md.</u>				STREET ADDRESS (If rural, give location) <u>R F D # 2 Box 6</u>			
3. NAME OF DECEASED: (First) <u>George</u>		(Middle) <u>N</u>		(Last) <u>Savage</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>March 1902</u>		9. AGE last birthday: <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Painter, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Horace Savage</u>				14. MOTHER'S MAIDEN NAME: <u>Bettie Jubellee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>		16. SOCIAL SECURITY No.: <u>219-14-2543</u>		17. INFORMANT & ADDRESS: <u>Ames (Sister) Mrs. Ames 728 Poplar Street, Philadelphia, Pa</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Sudden	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) _____ (County) _____ (State) _____		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
SIGNATURE <u>Earl L. Royce</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-26-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D. _____			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Nov. 29, 1955</u>		NAME OF CEMETERY OR BURIAL PLACE: <u>Mt. Zion Baptist</u>		LOCATION (City, town, or county) (State) <u>Painter, Accomack, VA</u>	
DATE REC'D BY LOCAL REG: <u>12-3-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>J. Edgar Thomas, Accomack, VA</u>			

BUREAU V. S.

DEC 8 1955

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>310 Buena Vista Ave.</u>				STREET ADDRESS (If rural, give location) <u>310 Buena Vista Ave.</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Jerry</u>		<u>Lee</u>		<u>Silcott</u>			
4. DATE OF DEATH		(Month)		(Day)		(Year)	
<u>11</u>		<u>29</u>		<u>19</u>		<u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday:	
<u>M</u>	<u>W</u>	<u>S</u>		<u>June 4, 1950</u>		<u>5</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Child</u>		<u>None</u>		<u>MARYLAND</u>		<u>U.S.B.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas J. Silcott</u>				<u>INEZ TEW</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>				<u>Mr Thomas Silcott, Same</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>756.2            Immediate cause (a) <u>Volvulus of the sigmoid</u>            DUE TO</p> <p>Antecedent cause(s)            Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)  <u>Congenital megacolon</u>            DUE TO</p>						<p><u>2 days</u></p> <p><u>life</u></p>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		DATE SIGNED			
<u>Earl H. Ryan</u>		<u>ASSISTANT MEDICAL EXAM.</u>		<u>11-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE, THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, county) (State)	
<u>Burial</u>		<u>12/1/1955</u>		<u>PITTSVILLE CEMETERY</u>		<u>SALISBURY, PITTSVILLE, MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-1-56</u>		<u>Mary W. Holloway</u>		<u>Hill &amp; Johnson Co Salisbury, Md.</u>		<u>Normant. Baker</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 5 1975

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## 11369 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>SOMERSET</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
12 TOWN <u>SALISBURY</u>		TOWN <u>PRINCESS ANNE</u>	19X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
82	<u>PENINSULA GENERAL HOSPITAL</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>Estelle M. Simpkins</u>		<u>November 5 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>		<u>July 27, 1878</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>77</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY:
<u>Housewife</u>	<u>At Home</u>	<u>Orville Md</u>	<u>USA</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>James Phoebeus</u>		<u>Mary Hayman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
<u>Douglas Simpkins, Princess Anne</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>			<u>8 hours</u>
ANTECEDENT CAUSE (S) (B) <u></u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11-5</u> , 19 <u>55</u> , to <u>11-5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>55</u> , and that death occurred at <u>7:48A</u> M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
<u>William R. Ellis, Jr.</u>		<u>Salisbury, Md</u>	<u>11-7-55</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>11-7-55</u>	<u>Asbury Methodist</u>	<u>Mt Vernon, Ind</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR'S ADDRESS	
<u>11-7-55</u>	<u>Mary W. Holloway</u>	<u>James L. Hunman, Princess Anne Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 17 1955

RECEIVED

1

11370 **CERTIFICATE OF DEATH**

Dr. Lynch

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>312 Charles St</b>				STREET ADDRESS (If rural give location) <b>312 Charles St</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>CORNELIA</b> (Middle) <b>CLYDE</b> (Last) <b>SMITH</b>				(Month) <b>NOV.</b> (Day) <b>24</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>July 5, 1878</b>		<b>9. AGE last birthday</b> <b>77</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>19</b>	<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wicomico Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Hambury</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Jane Evans</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. R. Clyde Smith (Son) 312 Charles St Salisbury, Maryland</b>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1</b> IMMEDIATE CAUSE <b>8</b>				<b>Anterior Myocardial Infarction</b>		<b>3 yrs</b>	
ANTECEDENT CAUSE(S) <b>10</b>				<b>Coronary Thrombosis</b>		<b>6 hours</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>2D. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Aug 1, 1964, to Nov 24, 1965, that I last saw the deceased alive on Nov 23, 1965, and that death occurred at 7:15 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>S. H. Lynch</i>				<b>ADDRESS</b> (Street, city, town, state) <b>606 Delaware Ave. Delmar, Del.</b>		<b>DATE SIGNED</b> <b>Nov. 24, 1965</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 28, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Western Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Edmonson Ave. Baltimore Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Holloway &amp; Co. Salisbury, Maryland.</b>		<b>ADDRESS</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11391

11371 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (In this place) <u>5 HOURS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKO</u>		<u>2342.2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>822 PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>2ND STREET EXT.</u>		✓	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLARD J. STEVENSON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>November 4 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUGUST 1, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CASHIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES G. STEVENSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HEARNE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-12-1836</u>		17. INFORMANT & ADDRESS <u>MRS NAOMI STEVENSON</u> <u>POCOMOKE CITY, MARYLAND</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Artery Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arteriosclerosis</u>				<u>Unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>11-4-55</u>, 19<u>55</u>, to <u>11-4</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11-4</u>, 19<u>55</u>, and that death occurred at <u>3:50</u> P.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>David J. Schum</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>Nov. 4, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY M. WATSON</u>		ADDRESS <u>Pocomoke Md</u>	
DATE <u>11-7-55</u>							

CERTIFICATE OF DEATH

Form 100-100

A. PERSONAL INFORMATION OF DECEASED

B. PLACE OF DEATH

DATE OF BIRTH  
PLACE OF BIRTH  
SEX  
RACE

DATE OF DEATH  
PLACE OF DEATH  
CITY  
COUNTY  
STATE

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

BY MEDICAL CERTIFICATION

DATE OF CERTIFICATION  
BY  
M.D.

BUREAU V. S.

NOV 17 1955

RECEIVED

11/22

EXHIBIT 100-100

RECEIVED BY BUREAU OF VITAL RECORDS, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND



11372

## CERTIFICATE OF DEATH

11392

Dr. Fisher

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY **Wicomico** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Salisbury**  
 TOWN **Salisbury**  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **Ren. Gen. Hospital**

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Wicomico**  
 CITY (If outside corporate limits, write RURAL and give nearest town) **Salisbury**  
 OR TOWN **Rural**  
 STREET ADDRESS (If rural give location) **R.D. # 2 (Shad Point)**

## 3. NAME OF DECEASED (Type or Print)

(First)

**JENNIE**

(Middle)

**ALICE**

(Last)

**TOWNSEND**

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

**Nov.****1 st****19 55**

## 5. SEX

**Female**

## 6. COLOR OR RACE

**White**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

**Widowed**

## 8. DATE OF BIRTH

**April 20, 1882**

## 9. AGE last birthday

**73**

Yrs.

## IF UNDER 1 YEAR

**6**

Months

## IF UNDER 24 HRS.

**11**

Days

**11**

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**House Work**

## 10b. KIND OF BUSINESS OR INDUSTRY

**at Home**

## 11. BIRTHPLACE (State or foreign country)

**Wicomico Co. Maryland**

## 12. CITIZEN OF WHAT COUNTRY?

**USA**

## 13. FATHER'S NAME

**Henry Mills**

## 14. MOTHER'S MAIDEN NAME

**Mary Jane Phillips**

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**No**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

**Mr. Walter H. Townsend (Son) R.D.# 2 (Shad Point) Salisbury, Maryland**

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

570.4 IMMEDIATE CAUSE (A) **Peritonitis**  
 ANTECEDENT CAUSE(S) DUE TO **Necrosis of bowel wall**  
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO **Gall stone ileus**  
 STATING UNDERLYING CAUSE LAST. (C)

## INTERVAL BETWEEN ONSET AND DEATH

**10 days**

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

**11-1-55**

## 19b. MAJOR FINDINGS OF OPERATION

**Generalized peritonitis; impacted gall stone ileus**

## 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.

## SIGNATURE

**William H. Fisher Jr. M.D.**

## ADDRESS (Street, city, town, state)

**Salisbury, Maryland Nov. 3 1955**

## DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

**Burial**

## DATE THEREOF

**Nov. 3, 1955**

## NAME OF CEMETERY OR CREMATORY

**Shad Point Cemetery at Shad Point (Near Salisbury, Md)**

## LOCATION (City, town, or county)

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

**Mary T. Holloway**

## 25. FUNERAL DIRECTOR'S SIGNATURE

**HOLLOWAY & COMPANY**

## ADDRESS

**SALISBURY MARYLAND**

DATE

**Nov 8 1955**

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1955

# CERTIFICATE OF DEATH

File No.

File No.

Place of Birth

Place of Birth

Residence

Residence

Residence

Residence

Age

Age

Age

Sex

Sex

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BUREAU V. S.

NOV 5 1955

RECEIVED

NOV 5 1955

NOV 5 1955

NOV 5 1955

NOV 5 1955

NOV 5 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11373  
Sartorius

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11393  
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <b>OR TOWN Snow Hill</b>		<b>23X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>82 Pen. Gen. Hospital</b>				STREET ADDRESS (If rural, give location) <b>R.D. # 2</b>			
3. NAME OF DECEASED: (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH		
<b>ELWOOD</b>		<b>J.</b>		<b>TWIGG</b>	<b>NOV. 10 19 55</b>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Married</b>		<b>May 27, 1919</b>		<b>36</b> yrs. Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Farming</b>		<b>Farmer on Farm</b>		<b>R.D. # 2 Snow Hill Md.</b>		<b>USA</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>James Emory Twigg</b>				<b>Rhoda Ellen Smullen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<b>2 Yes U.S. Army</b>				<b>Mrs. Ann S. Twigg (Wife) R.D. # 2 Snow Hill Maryland</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<b>21 hours</b>			
(a) Immediate cause				<b>Accidental</b>			
(b) Antecedent cause(s)				<b>Gun Shot Wound - Left Temp of Brain</b>			
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>21a. External Cause was Primary</b>		<b>21b. Place of Injury: Farm</b>		<b>21c. Snow Hill, Worcester, Md.</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
<b>Nov 9 1955 3 P.M.</b>		<b>While at work</b>		<b>Shot with a loaded gun which went off</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER			
<b>A. E. Sartorius</b>				<b>DATE SIGNED 11/19/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Nov. 13, 1955</b>		<b>Wicomico Memorial Park</b>		<b>Salisbury, Maryland</b>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>11-14-55</b>		<b>May W. Holloway</b>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

BUREAU V. 3

NOV 17 1955

RECEIVED

## 11374 CERTIFICATE OF DEATH

Reg. Dist. No. 882

## 1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS PENINSULA GENERAL Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY SOMERSET  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deal Island 19X-2

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

MURTEL WALTER

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 4. DATE (Month) (Day) (Year)

OF

DEATH: November 29 1955

## 9. AGE last birthday

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months Days

Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY:

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. (If Yes, give war or dates of service))

## 18. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

## IMMEDIATE CAUSE

(A)

DUE TO

## ANTECEDENT CAUSE (S)

(B)

DUE TO

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## INTERVAL BETWEEN ONSET AND DEATH

2 days

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/14, 1955 to 11/29, 1955 that I last saw the deceasedalive on 11/29, 1955, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

M. D.

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EXHIBIT A

ADJUTANT GENERAL

UNITED STATES ARMY

5 days

General Thompson

BUREAU V. S.

DEC 5 1955

RECEIVED

11/11 22 11/24

J. H. [unclear]



11388

## CERTIFICATE OF DEATH

Dr. Mitchell

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
X TOWN <b>Salisbury</b>				X TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D. # 1 (Fruitland)</b>				STREET ADDRESS (If rural give location) <b>R.D. # 1 (Fruitland)</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>THEODORE WESLEY WHAYLAND</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>NOV. 27 th 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 23, 1874</b>		<b>9. AGE last birthday</b> <b>81</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>4</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Siloam Md. Wicomico Co.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John William Whayland</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Jane Disharoon</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Wakeman Whayland 410 Dover St. (Son) Salisbury, Maryland</b>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>331X IMMEDIATE CAUSE (A)</b> <b>Cerebro Vascular Accident.</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Senility</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Hypertension.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 5/-, 19 55, to 11/26, 19 55, that I last saw the deceased alive on 11/26, 19 55, and that death occurred at 5:00P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Dr. Mitchell</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. Maryland Ave. Salisbury, Maryland</b>		<b>DATE SIGNED</b> <b>Nov. 30, 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 30, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Nov. 30, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED (Print Name)		SEX (Male or Female)		AGE (In Years, Months, and Days)	
DATE OF BIRTH (Month, Day, Year)		PLACE OF BIRTH (City, State, and Country)		OCCUPATION (If any)	
DATE OF DEATH (Month, Day, Year)		PLACE OF DEATH (City, State, and Country)		CAUSE OF DEATH (If known)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)		SIGNATURE OF PHYSICIAN (If known)	

*Charles V. ...*  
*Hypertension.*

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 104M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11375 **CERTIFICATE OF DEATH**

11396

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>MARYLAND</i> COUNTY <i>Wicomico</i>			
CITY OR TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY OR TOWN <i>Hebron</i>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS <i>Howard Street</i>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Winder</i>				<i>November 12 19 55</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>colored</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Newborn</i>	<b>8. DATE OF BIRTH</b> <i>November 12, 1953</i>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A</i>	
<b>13. FATHER'S NAME</b> <i>Thomas Lee Winder</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Delia Lab Horsey</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>1. DISEASES OR CONDITIONS, DIRECTLY LEADING TO DEATH</b> <i>162.5</i>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <i>Premature birth &amp; marked immaturity &amp; fetal alcoholism 2 hrs somn.</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>(24 weeks gestation) Wt 1lb 9oz</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <i>12 Nov</i> , 19 <i>55</i> , to <i>12 Nov</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12 Nov</i> , 19 <i>55</i> , and that death occurred at <i>4:15 AM</i> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Robert H. Sanderson Jr.</i>		<b>ADDRESS</b> (Street, city, town, state) <i>M.D. 9264 Division St Salisbury Wicomico</i>		<b>DATE SIGNED</b> <i>12 Nov 55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>	<b>DATE THEREOF</b> <i>11-12-55</i>	<b>NAME OF CEMETERY OR CREMATORY</b> <i>Green Acres Mem. Park</i>		<b>LOCATION</b> (City, town, or county) <i>Salisbury Wicomico</i>		<b>(State)</b>	
<b>24. REC'D BY REGISTRAR</b>	<b>REGISTRAR'S SIGNATURE</b> <i>Mary W. Holloray</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary A. Stewart</i>		<b>ADDRESS</b> <i>J. S. Stewart Funeral Home Salisbury, Md.</i>			
<b>DATE</b> <i>11-12-55</i>							

CERTIFICATE OF DEATH

Form 10-1-1955

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NEURAL DEGENERATION WITH DISSEMINATED SCLEROSIS

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NEURAL DEGENERATION WITH DISSEMINATED SCLEROSIS

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11376

## CERTIFICATE OF DEATH

11397

Dr. Long, Wm.

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>12 Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>77 Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>313 Union Ave.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>VELMA CATHELL WRIGHT</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 21 st 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 14, 1900</b>	<b>9. AGE last birthday</b> <b>55</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>7</b>	<b>IF UNDER 24 HRS.</b> Hours <b>1</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Nursing</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Reg. Nurse</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Denton, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Handy Livingston</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Ann Ennis</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. William M. Livingston (Brother) 202 Holland Ave. Salisbury, Maryland</b>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>170x IMMEDIATE CAUSE (A)</b>		<b>Pulmonary Edema</b>		<b>(Original mastectomy)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>		<b>Carcinomatosis</b>				<b>1943 or 1944</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>		<b>Old metastatic carcinoma of left breast</b>					
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>10/15/55</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Metastatic carcinoma</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. et work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 12/14/52, 19....., to 11/21/55, 19....., that I last saw the deceased alive on 11/21/55, 19....., and that death occurred at 2:45A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>William B. Long</b>		<b>ADDRESS (Street, city, town, state)</b> <b>M.D. Medical Center Salisbury, Maryland</b>		<b>DATE SIGNED</b> <b>Nov. 22 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 23, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Nov. 25, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
J. J. Jones, Jr.		Male		45		Jan 1, 1900		Baltimore, Md.		Baltimore, Md.		Heart disease		Jan 15, 1955		Baltimore, Md.		J. J. Jones, Jr.		J. J. Jones, Jr.		J. J. Jones, Jr.	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of completion		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
J. J. Jones, Jr.		Son		1234 Main St.		Baltimore		Md.		21201		Jan 15, 1955		J. J. Jones, Jr.		Registrar		Baltimore, Md.		555-1234		555-1234	

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NOV 25 1955

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## CERTIFICATE OF DEATH

12533

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <i>Salisbury</i>		<i>Life</i>		12 TOWN <i>Salisbury</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				134 Second St			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>William W. Wright</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>11 28 1955</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>Col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>		8. DATE OF BIRTH <i>5-4-89</i>	
				9. AGE last birthday <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Chance</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Wright</i>				14. MOTHER'S MAIDEN NAME <i>Lovie Wilson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>220-09-1453</i>		17. INFORMANT & ADDRESS <i>Sula Wright</i>			
		(If Yes, give war or dates of service)					
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						<i>2 weeks</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Atherosclerosis</i>						<i>Indefinite</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>14 Dec 1955</i> , to <i>28 Nov 1955</i> , that I last saw the deceased alive on <i>28 Nov 1955</i> , and that death occurred at <i>12:30 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>S. Hurrell</i>		ADDRESS (Street, city, town, state) <i>M.D. 652 W. Main Salisbury, Md. 21804</i>		DATE SIGNED <i>Dec 55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>12-1-55</i>		NAME OF CEMETERY OR CREMATORY <i>Green Acres Cem</i>		LOCATION (City, town, or county) (State) <i>Salisbury Md</i>	
24. REC'D BY REGISTRAR <i>ECB</i>		REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Booper M. Wick</i>		ADDRESS	
DATE <i>8 1955</i>							

## INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

REG. NO. 100

1. NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

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2. MEDICAL CERTIFICATION

3. SIGNATURE OF DECEASED

4. SIGNATURE OF WITNESSES

5. SIGNATURE OF PHYSICIAN

6. SIGNATURE OF CORONER

7. SIGNATURE OF JURY

8. SIGNATURE OF COURT

9. SIGNATURE OF STATE

10. SIGNATURE OF COUNTY

11. SIGNATURE OF CITY

12. SIGNATURE OF TOWNSHIP

13. SIGNATURE OF VILLAGE

14. SIGNATURE OF WARD

15. SIGNATURE OF BLOCK

16. SIGNATURE OF LOT

17. SIGNATURE OF HOUSE

18. SIGNATURE OF ROOM

19. SIGNATURE OF BED

20. SIGNATURE OF CHAIR

21. SIGNATURE OF TABLE

22. SIGNATURE OF CUPBOARD

23. SIGNATURE OF DRAWER

24. SIGNATURE OF DOOR

25. SIGNATURE OF WINDOW

26. SIGNATURE OF FLOOR

27. SIGNATURE OF CEILING

28. SIGNATURE OF WALL

29. SIGNATURE OF ROOF

30. SIGNATURE OF GROUND

31. SIGNATURE OF AIR

32. SIGNATURE OF WATER

33. SIGNATURE OF FIRE

34. SIGNATURE OF LIGHT

35. SIGNATURE OF SOUND

36. SIGNATURE OF SMELL

37. SIGNATURE OF TASTE

38. SIGNATURE OF TOUCH

39. SIGNATURE OF FEEL

40. SIGNATURE OF THINK

41. SIGNATURE OF KNOW

42. SIGNATURE OF BELIEVE

43. SIGNATURE OF TRUST

44. SIGNATURE OF HOPE

45. SIGNATURE OF FAITH

46. SIGNATURE OF CHARITY

47. SIGNATURE OF LOVE

48. SIGNATURE OF MERCY

49. SIGNATURE OF KINDNESS

50. SIGNATURE OF GENTLENESS

51. SIGNATURE OF PATIENCE

52. SIGNATURE OF SELF-CONTROL

53. SIGNATURE OF MODERATION

54. SIGNATURE OF TEMPERANCE

55. SIGNATURE OF SOBERNESS

56. SIGNATURE OF ORDER

57. SIGNATURE OF CLEANLINESS

58. SIGNATURE OF NEATNESS

59. SIGNATURE OF DECORUM

60. SIGNATURE OF PROPER BEHAVIOR

61. SIGNATURE OF GOOD MANNERS

62. SIGNATURE OF POLITE BEHAVIOR

63. SIGNATURE OF RESPECTFUL BEHAVIOR

64. SIGNATURE OF COURTEOUS BEHAVIOR

65. SIGNATURE OF GRACIOUS BEHAVIOR

66. SIGNATURE OF BENEVOLENT BEHAVIOR

67. SIGNATURE OF PHILANTHROPIC BEHAVIOR

68. SIGNATURE OF CHARITABLE BEHAVIOR

69. SIGNATURE OF ALMSGIVING BEHAVIOR

70. SIGNATURE OF GIVING BEHAVIOR

71. SIGNATURE OF CONTRIBUTING BEHAVIOR

72. SIGNATURE OF DONATING BEHAVIOR

73. SIGNATURE OF OFFERING BEHAVIOR

74. SIGNATURE OF PROVIDING BEHAVIOR

75. SIGNATURE OF SUPPLYING BEHAVIOR

76. SIGNATURE OF FURNISHING BEHAVIOR

77. SIGNATURE OF EQUIPPING BEHAVIOR

78. SIGNATURE OF ENDOWING BEHAVIOR

79. SIGNATURE OF DOWRYING BEHAVIOR

80. SIGNATURE OF BESTOWING BEHAVIOR

81. SIGNATURE OF GIFTING BEHAVIOR

82. SIGNATURE OF PRESENTING BEHAVIOR

83. SIGNATURE OF OFFERING BEHAVIOR

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169. SIGNATURE OF DONATING BEHAVIOR

170. SIGNATURE OF OFFERING BEHAVIOR

171. SIGNATURE OF CONTRIBUTING BEHAVIOR

172. SIGNATURE OF DONATING BEHAVIOR

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212. SIGNATURE OF OFFERING BEHAVIOR

213. SIGNATURE OF CONTRIBUTING BEHAVIOR